



Prior Authorizations 101

2021 IHCP Works
Annual Seminar



Agenda

- Prior Authorization Services
- Self-Referral Services
- Submission of Prior Authorization Requests
- Provider Portal and Authorizations
- Provider Portal Enhancements
- Timeframes
- Retro Authorizations
- NIA Magellan
- Dental Authorizations
- Newborn Processes
- Appeal Process
- Important Reminders
- How to Contact Us



Prior Authorization Services

Prior Authorization Services

All Inpatient Services	All Inpatient Behavioral Health admissions
Applied Behavior Analysis therapy services (ABA)	Intensive Outpatient Program Services
Transcranial Magnetic Stimulation	All outpatient therapies
Genetic Testing	Ambulance Transport – non-emergent
Home Health Care Services	Hearing Aids
Skilled Nursing Facility Services	Prosthetic and Orthotic devices
All powered or customized wheelchairs and supplies	Durable Medical Equipment
	All DME miscellaneous codes

*This is not an all-inclusive list, please verify authorization requirements via the Procedure Code Look-Up Tool

Prior Authorization Services

Pain Management Services <ul style="list-style-type: none">➤Facets➤Epidurals➤Facets Neurotomy➤SI Joints	Outpatient Services: <ul style="list-style-type: none">➤Cosmetic/Plastic/Reconstructive Procedures➤Spinal Cord Stimulators➤Implantable Pain Pumps
Organ Transplants	Partial Hospitalization Program (PHP)
Residential services	Services beyond benefit limits for members 20 years of age and under
Gender Dysphoria Surgeries	Any surgery or procedures that are potentially cosmetic or investigational will require a prior authorization

*This is not an all-inclusive list, please verify authorization requirements via the Procedure Code Look-Up Tool

Procedure Code LookUp Tool

PRIOR AUTHORIZATION

CareSource® evaluates prior authorization requests based on medical necessity, medical appropriateness and benefit limits.



Procedure Code Lookup

Complete Steps



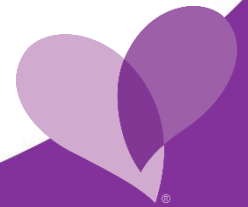
Choose Line of Business

-- Line of Business --

2

Enter a CPT/HCPCS Code

ABC90 or 92507



Self-Referral Services

Self-Referral Services

HHW Members

May receive self-referral services from Indiana Health Coverage Programs (IHCP) enrolled self-referral health partners who are not in the CareSource network.

CareSource reimburses self-referral services up to the applicable benefit limits and at IHCP Fee For Service (FFS) rates.

HIP Members

Must go to an in-network health partner; **OR** receive PA from CareSource to go to an out-of-network health partner.

Exceptions: Family planning & emergency services

CareSource reimburses self-referral services up to the applicable benefit limits and at a rate not less than the Medicare rate, or at 130% of Medicaid if no Medicare rate is available.



Self-Referral Services



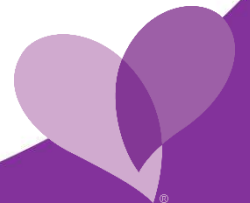
The following services are eligible for self-referral:

- Psychiatric services
- Family planning services

The following services are eligible for self-referral, but may only be provided to members receiving services through Hoosier Healthwise, HIP State Plan Basic/Plus and HIP Plus OR while receiving the additional HIP pregnancy-only benefits:

- Chiropractic services
- Eye care services, except surgical services
- Routine dental services
- Podiatry services

The Indiana Administrative Code *405 IAC 5* (Hoosier Healthwise) and *405 IAC 9-7* (Healthy Indiana Plan) provide further detail.



Submitting PA Requests

How to Submit PA Requests

Phone

1-844-607-2831

Fax

Fax the prior authorization form to 844-432-8924 including supporting clinical documentation. The prior authorization request form can be found on **CareSource.com**.

Mail

CareSource
Attn: IN Utilization Management
P.O. Box 1307
Dayton, OH 45401-1307

Provider Portal

Cite Auto Authorization

Prior Authorization Form

For prior authorization requests, please use the IHCP Prior Authorization Request Form.

It is located on the Forms page on **CareSource.com**:

- Hover over the **Providers** tab and click on **Forms**.
- Select your plan (**Indiana Medicaid**) in the dropdown menu.

Indiana Health Coverage Programs Prior Authorization Request Form			
Check the box of the entity that must authorize the service. (For managed care, check the member's plan, unless the service is delivered as fee-for-service.)	Fee-for-Service	<input type="checkbox"/> Cooperative Managed Care Services (CMCS)	P: 800-269-5720 F: 800-689-2759
	Hoosier Healthwise	<input type="checkbox"/> Anthem Hoosier Healthwise	P: 866-408-6132 F: 866-406-2803
		<input type="checkbox"/> Anthem Hoosier Healthwise - SFHN	P: 800-291-4140 F: 800-747-3693
		<input type="checkbox"/> CareSource Hoosier Healthwise	P: 844-607-2831 F: 844-432-8924
		<input type="checkbox"/> MDwise Hoosier Healthwise	See www.mdwise.org
		<input type="checkbox"/> MHS Hoosier Healthwise	P: 877-647-4848 F: 866-912-4245
	Healthy Indiana Plan (HIP)	<input type="checkbox"/> Anthem HIP	P: 1-844-533-1995 F: 866-406-2803
		<input type="checkbox"/> CareSource HIP	P: 844-607-2831 F: 844-432-8924
		<input type="checkbox"/> MDwise HIP	See www.mdwise.org
		<input type="checkbox"/> MHS HIP	P: 877-647-4848 F: 866-912-4245
Hoosier Care Connect	<input type="checkbox"/> Anthem Hoosier Care Connect	P: 1-844-284-1798 F: 866-406-2803	
	<input type="checkbox"/> MHS Hoosier Care Connect	P: 877-647-4848 F: 866-912-4245	
Please complete all appropriate fields.			
Patient Information IHCP Member ID (RID): Date of Birth: Patient Name: Address: City/State/ZIP Code: Patient/Guardian Phone: PMP Name: PMP NPI: PMP Phone:		Requesting Provider Information Requesting Provider NPI/Provider ID: Taxonomy: Tax ID: Provider Name:	
Ordering, Prescribing, or Referring (OPR) Provider Information OPR Physician NPI: Medical Diagnosis (Use of ICD Diagnostic Code Is Required) Dx1 Dx2 Dx3		Rendering Provider Information Rendering Provider NPI/Provider ID: Tax ID: Name: Address: City/State/ZIP Code: Phone: Fax:	
Please check the requested assignment category below: <input type="checkbox"/> DME <input type="checkbox"/> Inpatient <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Purchased <input type="checkbox"/> Observation <input type="checkbox"/> Speech Therapy <input type="checkbox"/> Rented <input type="checkbox"/> Office Visit <input type="checkbox"/> Transportation <input type="checkbox"/> Home Health <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Other <input type="checkbox"/> Hospice <input type="checkbox"/> Outpatient		Preparer's Information Name: Phone: Fax:	
Dates of Service Start Stop	Procedure/ Service Codes	Modifiers	Service Description Taxonomy POS Units Dollars
Notes:			
PLEASE NOTE: Your request MUST include medical documentation to be reviewed for medical necessity.			
Signature of Qualified Practitioner _____ Date: _____			



Provider Portal & Authorizations



Prior authorizations can be requested through the provider portal.

- Select Provider Authorizations and Notifications
 - Enter CareSource ID and Start Date of Service and select Search
 - Select Care Setting, Category and type of Prior Authorization
 - Enter provider information
 - Complete required fields and hit “Continue”
 - Select “Document Clinical” to continue
 - Click “Add” to choose Guideline of Service
 - Answer Guideline questions, hit Save and Submit Request

Provider Portal & Prior Auths



Provider Portal & Prior Auths

PROVIDERS

-

Care Management Referral

Dental Provider Login +

ER Referral

File Grievance

HIP Provider Cost Estimator

Pharmacy

Prior Authorization and Notifications

Provider Documents

Provider Maintenance

Quality Enhancer

Radiology Benefits Manager

Prior Authorization and Notifications

Medical (Inpatient & Outpatient)	Newborn Delivery Notification	Observation	Status





Provider Portal Enhancements

Provider Portal Enhancements

REMINDER: You can submit requests to update your authorization requests in the provider portal.

- Add Additional documentation or change dates of service
- Tip Sheet is located on the provider portal



Other Enhancements

AUTHORIZATION RECALL

Partially completed prior authorizations can now be saved for up to seven days

Recent Prior Authorizations ^

Page(s): 1

Record(s):4

Details	Authorization Number	Member ID	Description	Service Start Date	Status
	00[REDACTED]	[REDACTED]	Outpatient Elective	5/1/2020	Pending Decision
	00[REDACTED]	1[REDACTED]	Inpatient Emergency	4/22/2020	Pending Decision
	00[REDACTED]	1[REDACTED]	Outpatient Elective	4/21/2020	Pending Decision
	00[REDACTED]	1[REDACTED]	Outpatient Elective	4/6/2020	Fully Approved

Page(s): 1

Record(s):4

Saved Drafts ^

Drafts	Auth Type	Member ID	Provider ID	Created Date
Select Draft	Sleep Studies	[REDACTED]	346[REDACTED]	5/14/2020 3:01:12 PM

Authorization Request

Select Care Setting

☐ Inpatient

☐ Outpatient



Other Enhancements

AUTHORIZATION STATUS BY FACILITY ID

New search by Facility is available on the Prior Authorization and Notifications page.

Prior Authorization and Notifications

Medical (Inpatient & Outpatient)

Newborn Delivery Notification

Observation

Status

[Edit](#)

Recipient Id	Member Id	Member Info	Authorization Number	Facility
<div><div>Select the facility:</div><div></div><div>*</div></div> <div><div>Start Date:</div><div></div><div></div><div>*</div></div> <div><div>End Date:</div><div></div><div></div><div>*</div></div> <div><div>Search</div></div>				

Other Enhancements

AUTHORIZATION STATUS REASON

- Status Reason given
- **Void** Status Reason is **No Prior Auth Required**

Reference #: 0910TGW94

Reference #:	0910TGW94		
Description:	Outpatient Election		
Place Of Service:	80000 Hospital Inpatient Hospital		
Submitting Provider:	Hunting/Hospital Center Hospitalists Group		
Requesting/Ordering Provider:	Jordan Brown, Physician/Obstetrician-GYN F		
Servicing/Rendering Provider:	Hunting/Hospital Center Rehabilitation Facility F		
Facility:			
Member Information			
Member Name:	Doe/John A		
CareSource Id:	0447000000		
Birth Date:	01/01/1980		
Gender:	Male		
Service Event			
Diagnosis Code:	M50.02 Subacute or posttraumatic cervicogenic headache without disturbance		
Procedure:	61562 Laparoscopy, surgical, exploratory		
Line #1			
Requested Received Date:	11/10/2023 10:08 AM	Requested Units:	1
Start Date of Service:	11/14/2023	Authorized Units:	1
End Date of Service:	11/14/2023	Status:	Void (No Prior Auth Required)
Service Event			
Diagnosis Code:	M50.02 Subacute or posttraumatic cervicogenic headache without disturbance		

Other Enhancements

Pre-Service Authorization Appeals

- Pre-Service Authorization Appeal for denied authorizations (new option)
- Click **View Details**
- Complete the Form
- Attach member consent and documentation
- Post Service Appeals

Pre Service Authorization Appeals

Appeal Type: Authorization Denial-Medical ▼

Do you have a completed Member Consent form? ☒ Yes ☐ No


Please be sure to upload a copy of the Appointment of Representative (AOR) form along with the supporting documents. We will not be able to accept your appeal without the AOR.

Attachments: Please select a file using Choose File.
Once all of the files are uploaded, click Submit Appeal button to continue.
 No file chosen

File sizes must be limited to 100 MB.
Files Uploaded:

Expedited treatment based on member's condition: ☐ Yes ☐ No *

Reason for appeal/dispute and desired outcome:

Chat with us! 





Other Enhancements

PROCEDURE CODES DISPLAY ON PRIOR AUTHORIZATION CONFIRMATION

When submitting a prior authorization with multiple procedure codes, the **Confirmation** page now displays all relevant procedure codes submitted on the authorization.

ACCESS TO PRIOR AUTHORIZATION DOCUMENTATION AND LETTERS

Prior authorization documents and letters that are sent to providers are now available on the **Provider Documents** page as well as when checking the status of a prior authorization.





Prior Authorization Timeframes



Authorization Type	Decision
Standard pre-service	7 calendar days
Urgent pre-service	72 hours
Urgent concurrent	24 hours
Post service (retrospective review)	30 calendar days

Prior Authorization Timeframes

To check the status of a prior authorization request, call **1-844-607-2831** or to go through the provider portal





Retro-Authorization

INSTITUTIONAL & PROFESSIONAL



Prior/Retro Authorization For Ancillary Providers

Ancillary Provider Types

Radiology

Anesthesiology

Pathology

Hospitalist services

Labs

Other professional services performed in an inpatient or outpatient setting.



NIA Magellan


CareSource[™]

NIA Magellan

Procedures requiring prior authorization through NIA Magellan:

- CT/CTA
- MRI/MRA
- PET Scans
- Myocardial Perfusion Imaging (MPI)
- MUGA Scan
- Echocardiography
- Stress Echocardiography

Services NOT requiring prior authorization through NIA Magellan:

- Inpatient advanced imaging services
- Observation setting advanced imaging services
- Emergency room imaging services

NIA Magellan authorization phone number:

- 1-800-424-4883



A woman with short dark hair is shown in profile, sitting at a desk and looking at a computer screen. The background is a bright, modern office with other people working at desks.

NIA Magellan

How to submit

<https://www1.radmd.com/radmd-home.aspx>

or 1-800-424-4883

Note: Imaging procedures performed during an inpatient admission, hospital observation stay or Emergency room visit are not included in this program.



Dental Authorizations

Dental Authorizations

CareSource partners with SkyGen Dental to administer dental benefits. Dental authorization requests may be submitted via paper or online.

ONLINE:

Participating providers may contact the web portal team at ProviderPortal@scion.com to register for the Scion Provider Web Portal and request a demonstration.

Some of the time-saving features of the Dental Provider Web Portal include:

- View member service history, covered benefits and fee schedules.
- Create a member eligibility calendar and view real-time eligibility for multiple members.
- View authorization guidelines and required documentation prior to submitting authorizations.
- Submit authorizations with attachments for faster determinations.

PAPER:

Paper dental authorization requests may be sent to:

CareSource IN: Authorizations
P.O. Box 745
Milwaukee, WI, 53201

- Submit authorizations with attachments for faster determinations.

PHONE: 1-844-607-2831

Please reference our Dental Health Partner Manual for a list for services that require prior authorization.



Newborn Process

Newborn Process

CareSource does **NOT** require newborn notification

- Deliveries do not require authorization unless
 - Exceeds **3 days** for vaginal delivery
 - Exceeds **5 days** for C-Section
 - Newborn remains inpatient





Newborn Process

Eligibility Issues

- Providers have **60 days** to request retro-authorization
 - Change of eligibility must accompany request
 - Copy of Retro-Authorization is submitted with claim



Appeal Process



Expedited Appeals


- Call us at **1-844-607-2831** to expedite a clinical appeal.
- Expedited appeals will be resolved, and verbal notification will be made within 48 hours
- CareSource will decide whether to expedite an appeal within 24 hours



Provider Clinical/Claim Appeal Form



Provider Clinical/Claim Appeal Form

Please note the following to avoid delays in processing clinical/claim appeals:		
Include supporting documentation • Incomplete submission will be returned for additional information • Applicable timely filing limits apply		
Please indicate the following patient information:		
Member Name _____	Date of Service _____	
Member ID Number _____	Code/Service Not Covered _____	
	Place of Service _____	
Please indicate the following provider information:		
Provider Name _____	CareSource Provider ID _____	
Provider NPI Number _____	Claim Number _____	
Provider Telephone Number (____) _____	Requestor Name _____	
Select the most appropriate appeal type:	Include required documentation:	
<input type="checkbox"/> Claim Appeal — An adverse decision regarding payment for a submitted claim or a denied claim for services rendered to a CareSource member.	<ul style="list-style-type: none"> • Appeal form • Supporting documentation • Original remittance advice <p>The provider/facility rendering services has 365 days from the date of service to file a claim appeal.</p>	
<input type="checkbox"/> Clinical Appeal — A request to review a determination not to certify an admission, extension or stay, or other health care service conducted by a peer review who was not involved in any previous adverse determination /non-certification decision pertaining to the same episode or care.	<ul style="list-style-type: none"> • Appeal form • Records supporting medical necessity • Original remittance advice <p>The provider/facility rendering service has 180 days from the date of service to file a clinical appeal.</p>	
<input type="checkbox"/> Corrected Claim — Any correction of the date of service, procedure/diagnosis code, incorrect unit count, location code and/or modifier to a previously processed claim. Resubmit the entire claim with updated information as a Corrected Claim. If you disagree with the amount paid on a claim line, you will need to submit an appeal.	<p>Please send Corrected Claims to:</p> <p>CareSource ATTN: Claims Dept. P.O. Box 3607 Dayton, OH 45401-3607</p> 	
Reason for appeal request:		
Mail or fax all information to:		
Claim Appeals Department P.O. Box 2008 Dayton, OH 45401-2008	Clinical Appeals Department P.O. Box 1947 Dayton, OH 45401-1947	Provider Claim Appeals Coordinator Fax Number: 937-531-2388





Administrative Denials

Examples

- Late notification of inpatient admission
- Member not Eligible at time of request for authorization
- Late Retro Physician Denial
 - Needs to be submitted **within 60 days** from DOS
- Non-Covered Codes



A photograph of two hands, one from a person wearing a dark red sweater, reaching up to form a heart shape against a clear blue sky. The hands are positioned with fingers pointing towards the center, creating a heart outline.

Peer to Peer Review

- Upon request, CareSource will provide the clinical rationale or criteria used in making medical necessity determinations.
- You may request the information by calling or faxing the CareSource Medical Management Department.
- If you would like to discuss an adverse decision with physician reviewer, please call the Provider services line at **1-833-230-2168** within five business days of the determination.





Important Reminders



Important Information

- Provider responsibility
- Failure to obtain a prior authorization
- **Authorization is not a guarantee of payment for services.**
- CareSource does not require prior authorization for unlisted CPT codes.
 - However, we require a signed, clinical record be submitted with your claim to review the validity of the unlisted CPT code.
 - Claims submitted without clinical records for unlisted CPT codes will be denied.
 - Denials will be reconsidered through the claims dispute/appeal process with pertinent clinical records and should be sent directly to claims for consideration.
- **Services beyond applicable benefit limit for members 20 years of age and under require a prior authorization.**



Updates & Announcement

Updates & Announcements

Visit the Updates and Announcements page located on our website for frequent network notifications.

Updates may include:

- Medical, pharmacy and reimbursement policies
- Authorization requirements

Contact Us



CareSource Health Partner Engagement Representatives

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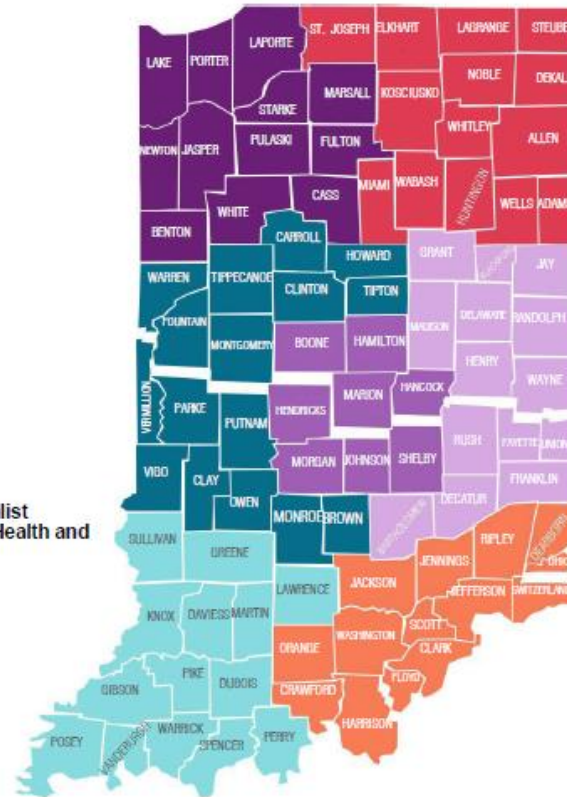
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Thank you!

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CareSource